

Statement of
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Assistant Secretary for Information and Technology
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Committee on Veterans' Affairs
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Thank you, Mr. Chairman. I am very pleased to appear before this committee representing the Secretary and the Department's information technology program. I am honored to return to the service of our country and to our veterans. I am most aware and energized by the size and complexity of our task.

While I have been here for only a short period, I believe I can make several useful observations. First, and perhaps foremost, I have seen a level of commitment and dedication to the mission on the part of everyone I have encountered that is truly remarkable.

Second, my impression so far is that the Department of Veterans Affairs has made significant progress over the last three years in attaining the Secretary's stated commitment to reform how "IT" gets done at the VA. However, much remains to be done.

Over the past two years, VA's Office of Information and Technology has initiated a rigorous information technology process. This process includes a disciplined project management methodology and an information technology portfolio management system that have been recognized by the Office of Management and Budget. We are well underway with an enterprise architecture that aims to align the business with the information technology plans, goals and efforts. We are in the final phase of rebuilding our nationwide telecommunications infrastructure, and we are implementing aggressive cyber security and privacy programs to ensure the protection of our infrastructure from attack, both external and internal, and to ensure the privacy of our service peoples' personal information.

In parallel to building a safe, secure, and technically current infrastructure across the VA system, we are working diligently to improve both service delivery and our

internal business practices. To improve the sharing of medical information between the Departments of Defense (DoD) and VA we have taken positive steps to develop data standards, as well as an interoperable health record. Communication and collaboration are key to our joint success in building a seamless veteran information environment.

Internally, regarding VETSNET, I would like, to reassure you, Mr. Chairman, that we are working hard to ensure that VETSNET remains on schedule.

Development of the final components is complete and undergoing vigorous testing. VBA is scheduled to begin a live test deployment in April 2004 at the Lincoln, Nebraska, RO, and we are committed to having VETSNET fully deployed to all regional offices by December 2005.

In the financial business arena, we will continue to coordinate with the Office of Management on successfully implementing CoreFLS in order to provide VA with an integrated financial and logistics system. This system is critical to the successful, efficient delivery of service to our nation's veterans and will allow the VA to effectively manage the resources entrusted to us. Without CoreFLS, VA will not be able to remove the financial and security material weaknesses that currently exist.

While there have been problems with the system and legitimate concerns raised over the selection of Bay Pines as the test site for this new integrated system, I believe that the system and the approach are sound and I fully support the Secretary's order that we will not rollout this system to other sites until we have remedied all critical issues identified at Bay Pines.

Finally, I believe it is important to mention again, an area of great interest to me and to this Subcommittee, cyber security. This remains one of our top priorities. We are currently implementing a comprehensive security configuration and management program designed to provide optimum protection of VA's infrastructure, from both outside and inside attacks. A comprehensive VA-wide cyber security program is vital to not only the security and privacy of our veterans, but also to our ability to provide the best service to our veterans.

VA/DoD Systems Interoperability

In April 2002, VA and DoD gained the approval of Office of Management and Budget (OMB) to proceed with implementing the Joint VA/DoD Electronic Health Records Plan – Health ePeople (Federal). Pursuant to the plan, VA and DoD are on schedule to achieve interoperability of health information systems by 2005, through the implementation of common standards, interoperable health information software, and interoperable data repositories. The plan is overseen by the VA/DoD Health Executive Council, co-chaired by the Under Secretary for Health in VA, and in DoD, by the Assistant Secretary of Defense, Health Affairs.



The development of interoperable health information systems will lead to a seamless medical record where authorized providers in one health system will have access to health data that resides in the other system. This seamless electronic access will have multiple advantages for beneficiaries of both military and VA health systems. Redundant tests and procedures will be eliminated, thereby freeing up scarce medical resources; providers in both systems will have real-time access to electronic data, therefore reducing medication errors such as adverse drug interactions or missed allergy checks; and the cost and burden of handling paper-based records will be eliminated.

Since implementing the plan, the Departments have made significant progress toward sharing medical data. In June 2002, VA and DoD began implementing Phase I of the plan, the Federal Health Information Exchange (FHIE) (formerly known as Government Computer-based Patient Record (GCPR)). FHIE supports the one-way transfer of pre-separation data on all retired and separated service members and reservists from the DoD Composite Health Care System (CHCS) into a secure repository where it is available for viewing by clinicians using the VA Computerized Patient Record System (CPRS). FHIE data are available for viewing in every VA medical facility. The initial release of FHIE permitted DoD to transfer laboratory, outpatient government pharmacy, and radiology report data to VA. Subsequent enhancements to FHIE now support the transfer of admission, disposition and transfer (ADT) data, consult reports and allergy data, retail pharmacy data from the DoD Pharmacy Data Transaction Service (PDTs), and the International Classification of Diseases, ninth edition, and Current Procedural Terminology (CPT) codes available in the DoD Standard Ambulatory Data Record. [DoD]

In addition to the one-way data flow from DoD to VA, FHIE supports the transfer of data from the FHIE repository to the Veterans Benefits Administration (VBA) for use in adjudicating disability claims. VBA can access the information about the patient using Compensation and Pension Records Interchange (CAPRI) seamlessly as needed. The Clinical Data Repository/Health Data Repository (CDR/HDR) effort, known as Clinical Health Data Repository (CHDR), is on target to demonstrate bi-directional interoperability and movement of pharmacy and demographic data in a prototype environment by the end of 2004.

In addition to FHIE and CHDR, the Departments are progressing in the development of interoperable software applications to include laboratory, credentialing and scheduling systems for beneficiaries. Presently, the Departments have the capability to support the one-way electronic ordering and results retrieval of labs by VA from DoD. The Departments are presently enhancing the Lab Data Sharing and interoperability software application to permit bi-directional support of lab requests and results retrieval. The Departments anticipate providing this enhanced capability by the 4th quarter of FY 04. The Departments are also prepared to test a prototype of interfaced

credentialing systems that will permit data sharing between VA's VetPro system and the DoD CCQAS (Centralized Credentialing Quality Assurance System). This application will decrease the time and resources needed to credential providers who need to practice in both VA and DoD health care settings. The Departments have formed a joint credentialing work group, developed the prototype, and are testing the prototype at approved locations. The Departments continue to work together on interoperable outpatient scheduling functionality between a DoD commercial system and a VA-built outpatient scheduling application and shared wellness content for e-portal systems for beneficiaries.

Phase II of the plan also addresses joint work on architecture, data, software, communication, security and information standards. As part of the federal Consolidated Health Informatics (CHI) effort led by VA, DoD and the Department of Health and Human Services, the Departments have adopted standards in five of twenty-four targeted clinical domain areas needed to support sharing of electronic health data and the others will be released soon. Each Department continues to develop and identify internal standards that will support future enhancements to software applications and permit interoperable health systems. Working together, DoD and VA have completed an updated mapping of their respective business activities, architectures, and standards comparison report in order to facilitate their continuing collaboration.

The Departments have also made significant progress toward Phase II of the plan to achieve bi-directional data exchange and interoperability. In August 2002, the Departments chartered a joint integrated project team to manage the development and acquisition of interoperable data repositories. Under this project, the DoD CDR and the VA HDR will support sharing of electronic health data.

In November, 2002, VA in coordination with DoD, developed a plan for an electronic pharmacy interface between CHCS and VistA to be tested at a joint venture site. The HUI (HUI is a Hawaiian word meaning "group" and is the name that participants chose for this effort) Pharmacy interface provides for the one-way electronic transmission of outpatient medication orders between Tripler Army Medical Center's CHCS system to VA's Spark Matsunaga Medical Center's VistA system for dispensing medications to VA patients. The interface improves patient safety by eliminating the need for VA to manually transcribe pharmacy orders which could result in transcription errors on patients referred to DoD by VA for shared care.

The Advant of the Electronic Medical Record

At VA's Veterans Health Administration (VHA), the Computerized Patient Record System (CPRS) allows clinicians to access medical records wherever patients are seen—in acute settings, clinics, exam rooms, nursing stations, and offices.

The system has been implemented at all VHA medical centers nationwide and at VHA outpatient clinics, nursing homes, and other sites of care since the late 1990's.

With CPRS, providers can access patient information at the point of care across multiple sites and clinical disciplines. It provides a single interface through which providers can update a patient's medical history, submit orders, and review test results and drug prescriptions.

The effectiveness of CPRS is due to its degree of integration with other Veterans Health Information System and Technology Architecture (VistA). Applications include:

- Automated order entry for consultations and procedures that alerts clinicians of a possible problem if the order is executed, as well as tracking and reporting of results;
- Clinical reminder system that allows caregivers to track and improve preventative health care for patients and help to ensure the initiation of timely clinical interventions;
- Remote data view function that allows clinicians to view a patient's medical history from another VHA facility to ensure that clinicians have access to all clinically relevant data from VHA facilities;
- Health summary reports that display relevant patient data, vital signs and measurements, etc., in a comprehensive report format; and
- Adverse drug reaction tracking with supportive drug reference software and linkage to Food and Drug Administration (FDA) systems to report data.

CPRS provides a single graphical user interface to data from a variety of packages including laboratory, radiology, pharmacy, dietetics, consults, and vitals allowing users to enter, view, and update information without having to log into each application separately. Providers can quickly flip through electronic pages of the chart to review or add information.

Providers are encouraged to enter progress notes directly into CPRS, either during or immediately after the encounter. Some providers use CPRS as an educational tool by graphing lab results so that patients can see their progress over time. For providers who prefer to dictate, notes are transcribed, then uploaded into the system and linked to patient encounters. Reports from external providers can be scanned, indexed, and incorporated into the patient's record.

CPRS also enables providers to electronically order lab tests, medications, diets, radiology tests, and procedures; record a patient's allergies or adverse reactions to medications; request and track consults; enter progress notes, diagnoses, and treatments for each encounter; and enter discharge summaries. Currently, 92 percent of VHA prescription orders are entered electronically.

In many cases, veterans obtain health care at more than one location. When necessary, veterans are referred to other sites for care, or may choose to seek treatment at different sites while traveling or vacationing. CPRS's remote data views feature enables data retrieval from all VA facilities at which a patient has sought care. When a user pulls up a patient record and requests remote data views, CPRS uses VHA's master patient index to obtain treatment sites for that veteran, and then retrieves and displays patient data from the sites selected by the user. The user can easily review and compare data from different sites.

This capability has virtually eliminated the problem of transferring paper records from location to location to provide care by enabling the clinician to review the veteran's complete medical record at the time of care. More importantly, the remote data view feature has reduced the likelihood that duplicate tests or incompatible medications are ordered for veterans seeking care at more than one site location of care.

The benefits of this electronic medical record to providers and patients are obvious: immediate access to information, elimination of duplicate orders, increased patient safety, and improved information sharing. VHA scientists, quality managers, and decision makers also use CPRS to collect data for clinical research, quality assurance, program planning, and financial management. Multiple users at different sites for a variety of purposes can access a single record simultaneously.

CPRS has been enhanced and refined continuously since its initial implementation, and has been recognized as one of the most sophisticated, broadly implemented electronic health record systems in the world. VHA was recognized in the Institute of Medicine publication *Leadership by Example* as a leader in the development of the following components:

- Computerized patient medical record for clinical documentation, clinician order entry and information retrieval;
- Performance measurement supported by electronic clinical reminders; and
- Patient safety reporting system to document adverse events and near misses.

Reduction of Medical Errors

Several features of the VHA's HealtheVet/Veterans Health Information System and Technology Architecture (VistA) Computerized Patient Record System (CPRS) electronic medical record reduce medical errors. First, the information is available -- and legible. Errors and mistakes found with verbal orders or interpretation of handwriting are eliminated. There are checks in the system for drug-drug interactions, and other contraindications. Order checks and reminders

are present to support clinical decision making. CPRS improves medical decision making and adherence to clinical guidelines. The Institute of Medicine (IOM) cited the development of an electronic health record as an essential to improve safety of health care. In the IOM 2002 publication *Leadership by Example*, it was noted “Computerized order entry and electronic medical records have been found to result in measurably improved health care and better outcomes for patients.”

The use of computerized provider order entry of medications is one of the areas in which VHA monitors the adherence to the usage of CPRS. Currently, 92 percent of all medication orders are entered directly by the ordering provider. The use of computerized provider order entry eliminates the patient safety hazards introduced by illegible handwriting and misinterpretation of medication order dosages, strengths and confusion of medication names.

Systems, such as the Bar Code Medication Administration (BCMA), are integrated into HealtheVet/Vista/CPRS to help ensure that patients receive the correct medication, in the correct dose, at the correct time. BCMA visually alerts staff, prior to administration of a medication, when the correct parameters are not met. The software reduces reliance on short-term memory by providing real time access to medication order information at the patient’s bedside.

BCMA also provides a system of reports to remind clinical staff when medications need to be administered, have been overlooked, or the effectiveness of doses administered should be assessed. The system also alerts staff to potential allergies, adverse reactions, special instructions concerning a medication order, and order changes that require action. During the medication administration process, visual alerts signal the nurse when the software detects a wrong patient, wrong time, wrong medication, wrong dose, or no active medication order. These alerts require a nurse to review and correct the reason for the alert before actually administering the drug. Computerization allows multiple users to access medication administration information at the same time without competing for or attempting to locate a paper record. Interruptions for the nurse administering medications and the potential for medications to be omitted during the administration process are reduced.

BCMA also helps prevent administering medications outside the medication administration window, because the information is presented to the medication nurse even if another individual is accessing the patient's medication administration information. The BCMA system offers many advantages to nurses. Order changes are communicated instantaneously to the nurse administering medications, eliminating the dependency on verbal or handwritten communication of order changes. Therefore, time delays are avoided and administration accuracy is improved.

VistA Rad (Radiology), filmless radiology component of HealtheVet VistA Integrated Medical Imaging System is a core image capture and archiving system that integrates all types of images, from advanced directives to multi-media gait studies, into CPRS, enabling clinicians to have a complete view of the patient's status. VistA Rad augments VistA imaging providing radiologists tools that enable them to "read" x-ray studies directly from computer screens without the need for x-ray film.

VHA's Office of Information continually collaborates with clinicians to improve and increase the tools available to augment the safe, effective delivery of health care to veteran patients.

VA implemented software in October 2003, to enable each VA medical facility to electronically request health insurance coverage information from **third party payers for non-service connected medical care**; this software was developed in accordance with the requirements of the Health Insurance Portability and Accountability Act (HIPAA). Also, the FY 2004 Appropriations Act includes a requirement that non service-connected veterans disclose current accurate health insurance information and annual income in order to receive health care services from VA. VA will implement this new requirement in June 2004.

The expectation that the HIPAA requirements, in conjunction with VA's efforts, would increase our capability for identifying third party health insurance, has been met with some level of disappointment, because the health care industry as a whole is not yet fully prepared to operate with any appreciable level of sophistication in this much-needed interaction between health care providers and health plans. While the capability now exists to bring health insurance coverage information into the electronic medical record, VA quickly discovered that simply building the infrastructure was not sufficient to eliminate the need for staff intervention for insurance discovery and verification, and thus reap the expected benefits. Another challenge has been establishing electronic connections to all health plans. VA has contracted with the largest health care clearinghouse with the largest number of payer connections, and while that is a major step forward, VA and health care providers as a whole have recognized that the challenge ahead is the achievement of timely electronic connections to all business partners. In light of these current constraints, VA is pursuing a combination of initiatives to acquire health insurance information, including a VA/DoD venture, mentioned below.

The Development of the Seamless Medical Record

In the early 1980's, VHA developed a set of core medical record applications for use in a variety of health care settings, including inpatient, outpatient, home health, and long-term care. These applications include: Laboratory, Radiology, Surgery, Pharmacy, Progress Notes, Discharge Summary, Mental Health, Consults/Request Tracking, Problem List, and Dietetics. In the mid-1990s, VHA

embarked upon an ambitious effort to improve the delivery and coordination of care by providing access to all clinical data through a single, integrated user interface, the Computerized Patient Record System (CPRS). Using CPRS, providers could quickly flip through the electronic pages, review lab and radiology results, enter orders, write progress notes and discharge summaries and receive timely alerts about recommended clinical interventions. CPRS quickly became the state-of-the-art tool for retrieving and entering clinical data.

In the late 1990's, VHA recognized that with CPRS, providers could access information about a patient at the point of care, but did not have seamless access to other medical record information about that same patient at another location within VHA. At that time, VHA developed and implemented an electronic Master Patient Index (MPI) that linked patient information across multiple sites. This index allows providers to access all patient health information at different locations of care.

In 1996, VHA implemented the ambulatory care reporting project, which supported the VHA's rapid move to outpatient services by providing a mechanism to electronically record the orders and text related to an encounter and the coded data required for third party billing. Prior to this time, only the total number of encounters was known, and not the diagnosis or the procedures performed. This project also enhanced the clinical reminder capabilities in CPRS, promoting the ability to remind providers of clinical interventions related to a diagnosis. For example, the reminder regarding foot examinations for diabetic veterans has contributed to a marked reduction in amputations related to diabetes. There is growing evidence that supports the conclusion that automated clinical information and decision support are critical to addressing the Nation's health care quality gap (Institute of Medicine 2001).

Using CPRS at one location of care, the provider can update the current patient's medical history, submit orders, and review test results and drug prescriptions and access all available electronic health information about the patient.


In 2001, the concept of sharing clinical data between VA and DoD became a reality through implementation of the Federal Health Information Exchange (FHIE). This initiative provided VA authorized providers with access to DoD patient health record information about separated military reservists and service members. Complying with appropriate privacy laws and requirements, FHIE functionality provides seamless access for VHA health care providers to DoD health information for those patients who seek care from VA.



We are pursuing a joint venture with DoD to help identify veterans' health insurance information that can be used to offset VA care costs. This Federal Shared Third Party Obligation Program, or F-STOP, could potentially enable VA to identify health insurance coverage by comparing existing Centers for Medicare and Medicaid Services data against veteran self-reported data, as well as



verifying insurance coverage information from known employers. This project is in the first phases of scope development and identification of responsibilities,

Core FLS

CoreFLS is an integrated commercial off-the-shelf (COTS) software financial and logistics system solution that will be used by every financial and logistics office within VACO, VHA, VBA, and NCA. While it is being developed to address material weaknesses and reportable conditions, it will be integrating the financial and logistics data into one data base and will allow accurate financial reporting and management review of centralized data. This initiative supports the President's Management Agenda and the VA strategic goal to provide a world-class service to veterans and their families through the effective management of people, technology, processes, and financial resources. 

Once implemented, it will be a fully-integrated system that will provide timely, easily  accessible financial and  logistical information. CoreFLS will provide better data management, automate data reconciliation, automate consolidated financial statements, and enable VA to comply with the Federal Financial Management Improvement Act (FFMIA) and other regulatory requirements. It will also establish a foundation of business processes for the VA enterprise architecture, reduce the number of stovepipe legacy systems, and align with VA and Federal e-government initiatives.

CoreFLS will be used by approximately 1,000 VA sites, including medical centers, outpatient clinics, nursing homes, domiciliaries, counseling centers, regional offices, and national cemeteries. Eventually, it will replace VA's existing Financial Management System (FMS), VHA's Integrated Funds Distribution Control Point Activity Accounting and Procurement (IFCAP) system, and Automated Engineering Management System/Medical Equipment Reporting System (AEMS/MERS). In addition, CoreFLS will interface with 74 specialized VA systems. The system will have an estimated 100,000 users and 15,000 concurrent users. The software will provide the following major functions: accounting, payments processing, receivables processing, debt management, asset management, billing, costing, financial analysis, budget, purchasing, contract management, and inventory management. Critical core activities will be the highest priority initially to expedite and maximize return on investment with no interruption to service.

CoreFLS is currently in System Development Milestone II of the project life cycle, which began in July 2002. Although this phase is scheduled to end in July 2004, due to issues at Bay Pines, the phase is likely to be extended. A "focus site" approach for the project was determined to be the best solution for the system development as the main emphasis of this phase is building and pilot testing the CoreFLS product at actual VA sites. Administration officials selected the focus sites, based upon VA protocol office-specific criteria, and identified the VHA

medical center at Bay Pines, FL, the VBA regional office at St. Louis, MO, and the NCA cemetery at Bushnell, FL (supported by the VHA medical center at Tampa). The focus sites are supported by VA's Financial Services Center and Austin Automation Center in TX, and VA Central Office in Washington, DC, for enterprise-wide activity.

CoreFLS has completed Build 1.1 of the Systems Development Phase, and as a result of the successful testing, VA leadership rendered a "Go – Decision to Proceed" with Build 1.2, a continuation of Systems Development. This phase encompasses the Integrated Test Cycles 1 and 2 (ITC2) and (ITC2), Operational/User Acceptance Testing (also called pilot testing), and Build 1.3. All components of the Systems Development phase have been incorporated and tailored within the CoreFLS products to meet the VA financial and logistics business needs and to meet the requirements for full implementation. After discussions with key VA Central Office leadership and stakeholders regarding potential Veterans Integrated Service Network (VISN) candidates for further testing, it was decided that VISN 8 (which includes VAMC Bay Pines), would serve as the best candidate for continued pilot testing of CoreFLS.

A comprehensive Fallback Plan was developed prior to implementation of pilot testing. There were lessons learned from the pilot, or Operational Test Phase 1 (OT1), that were collected from key stakeholders. The lessons learned recommendations were organized into seven topical areas: user provisioning, site readiness/communications, training, post-production support, help desk, finance, and logistics. CoreFLS has developed response time standards and continues to experience satisfactory performance. The transaction response time standard is 8 seconds, 90 percent of the time. The technical performance components of each user's interaction with the applications included the amount of network time; the forms server (middle tier) response time; and the database processing time.

CoreFLS has demonstrated the ability to sufficiently support station operations in a pilot or operational test environment and can support continued operational testing. Issues remain, however, as of February 20, 2004, 97.4 percent of identified issues have been resolved. The CoreFLS staff is working closely with pilot, or OT1 sites, to resolve issues and continue normal business operations.

Upon the completion of operational testing in its entirety, the CoreFLS National Deployment Rollout Plan will provide the framework for transitioning the project from the development phase to the deployment phase. The plan will focus on the activities required to migrate a site to CoreFLS, including the following: migration of the current legacy systems, management of rollout sites, and detailed planning required for preparation of the cutover phase. Execution of this plan will be accomplished by utilizing a set of detailed tools such as Reports, Interfaces, Conversions, Extensions (RICE) dashboard, Deployment Rollout schedules, Site Readiness database, and Work Breakdown Structures. These

tools will facilitate the rollup of the data into actionable, executive level information, while providing the granular level of data to perform analysis.

Successful implementation of CoreFLS will reduce the number of independent, disparate systems, resulting in an overall reduction of operations, maintenance, and life cycle costs. Any external system, not replaced in their entirety, must be modified to comply with CoreFLS requirements.

CoreFLS is a commercial off-the-shelf (COTS) product that was developed to track and control finances, vendor payouts and supply inventories. This system involves not just a change in technology but also a change in the way that its users will perform their jobs. We will intensely examine the lessons learned from this system and incorporate them into future system deployment methodologies.

For the immediate future and as directed by Secretary Principi, we will remain focused on resolving the Bay Pines issues before we deploy CoreFLS to additional sites. The initial placement of CoreFLS within Bay Pines is an excellent example of conducting a pilot in order to identify and correct problems prior to an expanded deployment of a new application or system.

While there is concern that the selection of Bay Pines was inappropriate because it is one of our largest hospitals, the advantage is that such a site should allow us to identify and resolve most issues. As of March 3, 2004, 97.8 percent of identified issues (4,238) have been resolved, with only 2.1 percent remaining open (93).

VETSNET

In the past few weeks, I have had the opportunity to learn of this Subcommittee's interests regarding the Veterans Service Network (VETSNET). These interests include such questions as: (1) When will VETSNET be deployed to all regional offices? (2) How do the security/fraud prevention capabilities of VETSNET differ from the current system? and (3) What is the justification for the fiscal year 2005 budget request for \$5 million in funding for increased platform capacity for VETSNET?

Before I answer those questions, I would like to explain my own review and understanding of this important project.

In testimony before this Subcommittee on April 4, 2001, Secretary Principi recognized the past problems of VETSNET. According to Secretary Principi's testimony, these problems included the fact that this project had been under development far too long, that its development had been delayed as new technologies and technical approaches came and went, and that over time VETSNET had suffered from a lack of focus, the absence of clear goals and, at some points, inadequate management.

Secretary Principi also recognized that those problems were behind us and that a VETSNET management plan that addressed these problems was in place. However, he informed this Subcommittee that, because of his concern about critical issues of performance and effective systems integration, he had directed an independent audit of the overall system before proceeding to a fully operational status of VETSNET.

As explained by Secretary Principi, the purpose of this audit was to assure “that this system will meet all the security, functional, and performance requirements that we have set for it.” Secretary Principi committed to this Subcommittee that if VETSNET were found to meet our needs, we would not hold past failures against it and would go into production with the system. On the other hand, if VETSNET were found not to meet our needs, we would terminate its development.

The independent audit directed by Secretary Principi was conducted during the summer of 2001. Since the results of the independent audit of VETSNET were favorable, Secretary Principi permitted work on this project to continue.

In testimony before this Subcommittee on September 26, 2002, my predecessor, Assistant Secretary for Information and Technology, Dr. John Gauss, explained that both he and Admiral Daniel Cooper, Under Secretary for Benefits, had personally reviewed VETSNET and recommended to Secretary Principi that this project continue.

According to Dr. Gauss, there was a plan in place for VETSNET and all milestones had been met. Dr. Gauss also noted that there was a successful “glide path” in place for meeting the April, 2004, deadline for the beginning of VETSNET deployment.

I fully recognize the concerns of this Subcommittee regarding VETSNET, so I believe that it is important to review the progress that has been made as well as what remains to be completed. From the review conducted by Admiral Cooper and Dr. Gauss, it is clear that satisfactory actions have been taken to successfully address many long-standing issues identified by this Subcommittee.

Two actions (assignment of a dedicated VETSNET Program Manager, and revalidation of user requirements) have been completed and three are satisfactorily underway (end-to-end testing, Benefits Delivery Network continuity plan, and integrated project management plan). Also, it is very significant that we have already developed, deployed and are enjoying the benefits, nationwide, of two of the four major VETSNET applications.

The two applications that have already been developed and deployed and are in use in all Regional Offices are Modern Award Processing – Development or

MAP-D, which is used to establish and develop the claim, and Rating Board Automation (RBA) 2000, which supports rating the claim.

The remaining two applications are Award, which is used to prepare the claim award, and the Financial and Accounting System or FAS, which is used to pay the claim. These two applications are undergoing extensive testing.

We are already enjoying the benefits of both MAP-D and RBA 2000 and next month (April, 2004), we will begin live field testing of all four of the VETSNET applications in the Lincoln, Nebraska, Regional Office.

We have learned important lessons about the deployment of new applications. Many of these have been documented in the November 15, 2001, Information Technology Task Team Report to the Under Secretary for Benefits. For example, lessons learned about the deployment of RBA 2000 include the fact that there is a steep learning curve, that this learning curve often includes a change to the business process as well as the introduction of a new technology, that adequate testing must be done prior to deployment, and that an increase in the claims processing work load can further complicate the deployment.

In testimony before this Subcommittee in March, 2002, my predecessor, Dr. John Gauss, advised that actual deployment of VETSNET would be determined as a function of when VBA can afford to insert a new system into the regional offices, with the companion learning curve, such that the impact on working off backlogged claims can be effectively managed. That remains the case today.

We have also learned that initial deployment at a large facility may not be the best approach, and that introduction of a new system with a new way of doing business requires a completely collaborative training and implementation process. Mr. Chairman, it is for these and other reasons that we have chosen to begin live field testing of VETSNET in the Lincoln Regional Office in April 2004.

Therefore, we are planning the deployment of VETSNET based on these and other past experiences. We have built these past experiences into our deployment planning, and what we learn at Lincoln and at subsequent sites will also be incorporated into our deployment implementation.

The Lincoln, Nebraska, Regional Office will begin using the remaining two applications next month (April, 2004). These two are Award, which is used to prepare the claim award, and the Financial and Accounting System or FAS, which is used to pay the claim.

It is our intention that these two applications will be used by all remaining Regional Offices by December, 2005.

Together, the Under Secretary for Benefits and I will continue to review this timeline and monitor the impact of these and other factors.

The next question I would like to address is “How do the security/fraud prevention capabilities of VETSNET differ from the current system?”

The VETSNET architecture builds in automated tools to protect against fraudulent claims processing. The three-tiered client/server architecture provides the basis for instituting security at multiple levels. Access to VETSNET applications is monitored by the Common Security System.

This means that there are stringent approval chains in the rating and award processes that have been implemented for the VETSNET applications MAP-D, RBA 2000 and Award. Three electronic signatures are required from three distinct users for large payments and other special situations, such as retroactive awards above established thresholds. The user generating the award cannot authorize the same award.

Additionally, the Finance and Accounting System or FAS allows real time and online auditing. FAS also allows online reporting of suspicious circumstances for immediate review and action by appropriate staff.

Using the Corporate Database, historical data is retained online and is available for validation and auditing. All database updates are journalized, which creates and maintains an accurate, online audit trail (i.e., all efforts to create, edit or delete records are recorded). Also, VETSNET will ultimately increase the amount of data available for review for consistency, meaning that more historical data will be capable of being mined using the Veterans Benefits Administration's Data Warehouse tools. Data mining will enhance the ability to detect possible security or fraud incidents. Also, use of VETSNET should increase the consistency and equity of awards across all regional offices.

Finally, VETSNET addresses several of the recommendations contained in the Office of Inspector General Report, “Audit of the Compensation and Pension Program's Internal Controls at VA Regional Office St. Petersburg, FL” including (1) establishing a positive control (system edit keyed to employee ID number) that ensures employee claims are adjudicated only at the assigned regional office or jurisdiction and prevents employees from adjudicating matters involving fellow employees and VSOs at their home office, (2) the feasibility of direct input and storage of rating decisions in the system, (3) establishing a system field for third-person authorization and a control to prevent release of payments greater than the established threshold without third-person authorization and (4) the use of Social Security Number (or other acceptable number) to tie employee system access to a perpetual, unique identifier.

The next VETSNET question I would like to address is "What is the justification for the fiscal year 2005 budget request for \$5 million in funding for increased platform capacity for VETSNET?"

The basis of this question is the February 4, 2004, testimony by Secretary Principi regarding the Department of Veterans Affairs' proposed budget for fiscal year 2005. In that testimony, Secretary Principi stated that sufficient platform capacity is required to successfully deploy VETSNET and to ensure the continued and uninterrupted payment of benefits to deserving veterans and their beneficiaries.

In that same testimony, Secretary Principi noted that the Veterans Benefits Administration (VBA) has made excellent progress in addressing the Presidential priority of improving the timeliness and accuracy of claims processing, including the facts that (1) VBA has hired and trained more than 1,800 new employees in the last three years, and (2) that the productivity of the VBA staff has increased dramatically as well, with the average number of claims completed per month growing by 70 percent, from 40,000 to 68,000.

It is this dramatic increase in claims processing that is the main basis of our request for increased platform capacity. Additional supporting factors are (1) mandated use of applications in all regional offices and (2) nationwide deployment and use of the first two VETSNET applications (MAP-D and RBA 2000). This dramatic increase in workload has been reflected in production system usage charts, and the transaction volume is predicted to more than double over the next two years.

Therefore, we have filed this initiative in order to increase the capacity of the VBA corporate production system processors, memory and Direct Access Storage Device (DASD). This increase in capacity is absolutely necessary to support the continued deployment of applications for VETSNET, including those to be used to deliver the Compensation and Pension, Education and Vocational Rehabilitation and Employment benefits.

In summary, it is our projection (and the basis of this request) that (1) additional processors are required to sustain an acceptable performance level given the anticipated increase in transaction volume, (2) additional memory is required in order to support the increased number of concurrent applications processing and (3) additional DASD is required to support the growth of the corporate database as it expands to accommodate the storage of information required to administer the benefit programs of the VBA business services.

Mr. Chairman, VETSNET has been a long time in coming, but I believe we must continue to move forward to see it through to completion. This project has been made stronger as the result of each scrutiny it has undergone. We are already

enjoying the benefits of two of the four major VETSNET applications and the remaining two will begin live field testing next month.

I know this is a very sensitive issue and I will personally oversee progress to ensure VETSNET continues to meet the projected time line. Admiral Cooper and I have agreed to continue the close monitoring established under my predecessor and we will do everything in our power to keep VETSNET on the right track.

The Patient Financial Services System

The Patient Financial Services System (PFSS) Project, as many of you know, is the implementation of a COTS health care billing and accounts receivable software system intended to replace the legacy VistA Integrated Billing and Accounts Receivable applications.

Consistent with commercial best practices, implementation of the PFSS pilot should demonstrate increased revenues through three avenues:

- First, staff efficiency through streamlined, standardized, re-engineered processes;
- Second, more accurate bills through better charge capture and a fully-integrated billing solution; and
- Third, shortened bill lag times through greater effectiveness in the automated processes.

To date, we have selected a system integrator and a COTS vendor for the project, and have completed the Analysis Phase.

The Cleveland VA Medical Center has been identified as the first implementation test site for PFSS, and a project management office has been established at that location. Hardware to support the new COTS software has been procured, delivered and installed at Cleveland.

Once the COTS product was selected, the integrator's analysis phase commenced. This phase ended in February 2004. Critical insights into the complexities of the task ahead have emerged from this analysis, including the knowledge that additional enabling functionality will be required

What we have learned from the Analysis Phase has necessarily forced a reconsideration of the development and implementation timeline. Reassessment of timeframes, as rapidly as possible, is underway at the present time, consistent with thorough investigation and the objective of proceeding as good stewards of the VA Enterprise and with all due speed toward a successful implementation of PFSS.

Cyber Security and Privacy



Finally, another area of great interest to me and to this Subcommittee is that of cyber security. In many ways, this must remain one of our top priorities. We cannot and will not delay our forward movement in this area, so we are implementing as rapidly as possible the recommendations contained in the report of the Inspector General regarding the Blaster worm. The focus of this entire effort is a comprehensive security configuration and management program designed to provide optimum protection of the VA infrastructure from both outside and inside attacks.

VA is a diverse organization, with broad business operations and requirements, encompassing the largest health care organization in the Nation and conducting financial services on the order of some of the Nation's largest financial institutions in the country. In addition, we are ensuring that all activities involving the collection, sharing and warehousing of individually identifying health and other information comply with the privacy requirements of the Health Information Portability and Accountability Act, the Privacy Act, the E-Government Act and related regulations and standards. -

Smart Card

In order to address our business requirements, seek improvements in operations, and reduce the Department's risk exposure, VA has an enterprise-wide initiative that calls for issuance of **smart cards** to each VA employee, as well as designated contractors and business affiliates. This OMB-approved initiative is formally known as the Authentication and Authorization Infrastructure Project (AAIP), which also includes an enterprise public key infrastructure (PKI) implementation and a modern Identity and Access Management (IAM) solution. AAIP is directly in line with emerging Federal policy where VA's smart cards will be used to provide three core functions: act as an official Federal ID card; provide a secure method for VA staff to manage digital credentials that support authentication, digital signature, and encryption services; and, over the course of time, allow VA to move to more cost-effective physical access controls at VA facilities.

VA is confident that the incorporation of smart cards will provide a number of benefits, acting as a foundation to implement a number of business process improvements, such as:

- Smart cards are part of VA's strategy to address our "material weakness" deficiencies related to authentication and account management. Smart cards will support VA activities related to Health Insurance Portability and Accountability Act compliance.
- Authentication using a smart card will be the basis for single sign-on.
- VA is exploring how we can streamline business processes using digital signatures in automated workflow transactions.

- Smart cards will enable enterprise physical access management, where VA anticipates potential savings of up to 20 percent.

Smart cards hold great promise at VA, and while it is understood that there may be challenges with the implementation of these smart card activities, VA is moving forward in a prudent manner. Extensive prototype testing will be conducted to protect the investment in this area, and VA will remain committed to gaining the benefits represented by this technology as VA enterprise evolves to serve its constituents and employees.

This concludes my written statement. Thank you, again, Mr. Chairman, for the opportunity to discuss these important matters.